

**RULES  
OF  
TENNESSEE DEPARTMENT OF HEALTH  
BOARD FOR LICENSING HEALTH CARE FACILITIES**

**CHAPTER 1200-8-2  
STANDARDS FOR PRESCRIBED CHILD CARE CENTERS**

**TABLE OF CONTENTS**

1200-8-2-.01	Definitions	1200-8-2-.08	Life Safety
1200-8-2-.02	Licensing Procedures	1200-8-2-.09	Infectious and Hazardous Waste
1200-8-2-.03	Disciplinary Procedures	1200-8-2-.10	Records and Reports
1200-8-2-.04	Administration	1200-8-2-.11	Child, Parent or Responsible Party's Rights
1200-8-2-.05	Admissions, Discharges, and Transfers	1200-8-2-.12	Policies and Procedures for Health Care Decision-Making
1200-8-2-.06	Basic Services	1200-8-2-.13	Disaster Preparedness
1200-8-2-.07	Building Standards	1200-8-2-.14	Appendix

**1200-8-2-.01 DEFINITIONS.**

- (1) Administrator. The individual designated by the licensee or the governing body to be the person responsible for the day to day supervision and operation of the PCCC and may be either the licensee or the nursing director.
- (2) Adult. An individual who has capacity and is at least 18 years of age.
- (3) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.
- (4) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.
- (5) Board. The Tennessee Board for Licensing Health Care Facilities.
- (6) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a patient to make health care decisions while having the capacity to do so. A patient shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a patient shall have the burden of proving lack of capacity.
- (7) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary function in a child, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a child where cardiac or respiratory arrest has occurred or is believed to be imminent.
- (8) Certified Master Social Worker. A person currently certified as such by the Tennessee Board of Social Worker Certification and Licensure.
- (9) Certified Nurse Practitioner. A person who is licensed as a registered nurse and has further been issued a certificate of fitness to prescribe and/or issue drugs by the Tennessee Board of Nursing.

(Rule 1200-8-2-.01, continued)

- (10) Certified Respiratory Technician. A person currently licensed as such by the Tennessee Board of Respiratory Care.
- (11) Child or Children. A person or persons under 18 years of age.
- (12) Child Care. The provision of supervision, protection, and meeting, at a minimum, the basic needs of a child for three (3) or more hours a day, but less than twenty-four (24) hours a day.
- (13) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.
- (14) Dentist. A person currently licensed as such by the Tennessee Board of Dentistry.
- (15) Department. The Tennessee Department of Health.
- (16) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.
- (17) Developmentally Appropriate. As defined by the National Association for the Education of Young Children, developmentally appropriate practice is the use of child development knowledge to identify the range of appropriate behaviors, activities and materials for a specific age group. This knowledge is used in conjunction with understanding about an individual child's growth patterns, strengths, interests, and experiences to design the most appropriate learning environment. Developmentally appropriate curriculum provides for all areas of a child's development: physical, emotional, social, and cognitive through an integrated approach.
- (18) Dietitian. A person currently licensed as such by the Tennessee Board of Dietitian/Nutritionist Examiners.
- (19) Do Not Resuscitate (DNR) Order. For purposes of this chapter, an order entered by the child's treating physician, in consultation with the parent, in the child's medical record which states that in the event the child suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.
- (20) Electronic Signature. The authentication of a health record document or documentation in an electronic form achieved through electronic entry of an exclusively assigned, unique identification code entered by the author of the documentation.
- (21) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.
- (22) Emergency. Any situation or condition which presents an imminent danger of death or serious physical or mental harm to children.
- (23) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.
- (24) Functional Assessment. An evaluation of the child's abilities and needs related to self care, communication skills, social skills, motor skills, pre-academic areas, play with toys/objects, growth and development appropriate for age.

(Rule 1200-8-2-.01, continued)

- (25) **Group.** A specific number of children comprising an age range, assigned to specific staff in an assigned space, which is divided from the space of other groups by a recognizable barrier to define limits and to reduce distractions.
- (26) **Guardian.** A judicially appointed guardian or conservator having authority to make a health care decision for an individual.
- (27) **Hazardous Waste.** Materials whose handling, use, storage, and disposal are governed by local, state, or federal regulations.
- (28) **Health Care.** Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).
- (29) **Health Care Decision.** Consent, refusal of consent or withdrawal of consent to health care.
- (30) **Health Care Decision-maker.** In the case of an individual who lacks capacity, the individual's health care decision-maker is one of the following: the individual's health care agent as specified in an advance directive, the individual's court-appointed guardian or conservator with health care decision-making authority, the individual's surrogate as determined pursuant to Rule 1200-8-2-.12 or T.C.A. §33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.
- (31) **Health Care Institution.** A health care institution as defined in T.C.A. § 68-11-1602.
- (32) **Health Care Provider.** A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business of practice of a profession.
- (33) **High School Diploma.** As used in the context of staff qualifications, refers to a document recognizing graduation from a legally approved institution, public or private, based on the issuing state's required number of academic credits, including passing a GED test. As used in this Chapter, a certificate or statement of attendance or similar document, or correspondence or video courses, do not qualify as a high school diploma.
- (34) **Holding Out to the Public.** Advertising or soliciting the public through the use of personal, telephone, mail or other forms of communication to provide information about services provided by the facility.
- (35) **Individual instruction.** An individual's direction concerning a health care decision for the individual.
- (36) **Infant.** A child who is six (6) weeks through fifteen (15) months of age.
- (37) **Infectious Waste.** Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.
- (38) **Licensee.** The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.
- (39) **Licensed Clinical Social Worker.** A person currently licensed as such by the Tennessee Board of Social Workers.
- (40) **Licensed Practical Nurse.** A person currently licensed as such by Tennessee Board of Nursing.
- (41) **Medical Emergency.** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be

(Rule 1200-8-2-.01, continued)

expected to result in placing the child's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part, which includes labor when delivery is imminent, when there is inadequate time to effect safe transfer to a hospital prior to delivery, or when a transfer may pose a threat to the health and safety of the child or the unborn child.

- (42) **Medical Record.** Medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations, and other written electronics, or graphic data prepared, kept, made or maintained in a facility that pertains to confinement or services rendered to patients admitted or receiving care.
- (43) **Medically Inappropriate Treatment.** Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the patient or other medical or surgical treatments to achieve the expressed goals of the informed patient. In the case of the incompetent patient, the patient's representative expresses the goals of the patient.
- (44) **Mid-Level Practitioner.** A certified nurse practitioner or a licensed physician assistant.
- (45) **N.F.P.A.** The National Fire Protection Association.
- (46) **Nursing Director.** A licensed registered nurse providing continuous supervision of PCCC services and managing the operations of the facility.
- (47) **Occupational Therapist.** A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.
- (48) **Occupational Therapy Assistant.** A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.
- (49) **Optometrist.** A person currently licensed as such by the Tennessee Board of Optometry.
- (50) **Parent.** A biological, legal or adoptive parent, guardian, or a legal or physical custodian who has primary responsibility for a child.
- (51) **Person.** An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.
- (52) **Personally Informing.** A communication by any effective means from the patient directly to a health care provider.
- (53) **Pharmacist.** A person currently licensed as such by the Tennessee Board of Pharmacy.
- (54) **Physical Therapist.** A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.
- (55) **Physical Therapy Assistant.** A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.
- (56) **Physician.** An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.
- (57) **Physician Assistant.** A person who is licensed by the Tennessee Board of Medical Examiners and Committee on Physician Assistants and has prescription writing authority pursuant to T.C.A. 63-19-107(2)(A).

(Rule 1200-8-2-.01, continued)

- (58) **Plan of Care.** The comprehensive plan for implementation of medical, nursing, psychosocial, developmental, and educational therapies to be provided upon admission and shall include necessary equipment to meet the child's need, and the plan will be revised to include recommended changes in the therapeutic plans. The disposition to be followed in the event of emergency situations will be specified in the Plan of Care.
- (59) **Podiatrist.** A person currently licensed as such by the Tennessee Board of Registration in Podiatry.
- (60) **Power of Attorney for Health Care.** The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.
- (61) **Prescribed Child Care Center (PCCC).** A nonresidential child care, health care/child care center providing physician prescribed services and appropriate developmental services for six (6) or more children who are medically and/or technology dependent and require continuous nursing intervention. Child care for purposes of this section means the provision of supervision, protection, and meeting the basic needs of children, who are not related to the primary caregivers, for three (3) or more hours a day, but less than twenty-four (24) hours a day. As part of the continuum of care for medically dependent children, the center provides a triad of medically necessary services: skilled nursing care, developmental programming, and parental training. Prescribed child care (PCCC) provides a less restrictive alternative to hospitalization and reduces the isolation often experienced by the homebound, medically dependent child and family. The purpose of prescribed childcare is health care, but does not exclude other services.
- (62) **Psychologist.** A person currently licensed as such by the Tennessee Board of Examiners in Psychology.
- (63) **Qualified Emergency Medical Service Personnel.** Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.
- (64) **Reasonably Available.** Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the child's health care needs. Such availability shall include, but not be limited to, availability by telephone.
- (65) **Registered Nurse.** A person currently licensed as such by the Tennessee Board of Nursing.
- (66) **Registered Respiratory Therapist.** A person currently licensed as such by the Tennessee Board of Respiratory Care.
- (67) **Shall or Must.** Compliance is mandatory.
- (68) **Social Worker.** A person who has at least a bachelor's degree in Social Work or related field, and preferably, two (2) years medical social work or other community based work experience.
- (69) **Speech Pathologist.** A person currently licensed as such by the Tennessee Board of Communications Disorders and Sciences.
- (70) **State.** A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.
- (71) **Supervising Health Care Provider.** The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(Rule 1200-8-2-.01, continued)

- (72) Surrogate. An individual, other than a patient's agent or guardian, authorized to make a health care decision for the patient.
- (73) Toddler. A child who is sixteen (16) months through thirty (30) months of age.
- (74) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the child.
- (75) Universal Do Not Resuscitate Order. A written order that applies regardless of the treatment setting and that is signed by the patient's physician which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The Physician Order for Scope of Treatment (POST) form promulgated by the Board for Licensing Health Care Facilities as a mandatory form shall serve as the Universal DNR according to these rules.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 39-11-106, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-224, and 68-11-1802. **Administrative History:** Original rule certified June 7, 1974. Amendment filed July 3, 1984; effective August 1, 1984. Repeal and new rule filed May 22, 1986; effective June 21, 1986. Amendment filed April 1, 1992; effective May 16, 1992. Amendment filed January 6, 1995; effective March 22, 1995. Repeal filed March 18, 2000; effective May 30, 2000. New rule filed June 13, 2002; effective August 27, 2002. Amendment filed May 16, 2006; effective July 30, 2006. Amendment filed February 7, 2007; effective April 23, 2007.

#### **1200-8-2-.02 LICENSING PROCEDURES.**

- (1) No person, partnership, association, corporation, or state, county or local government unit, or division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any Prescribed Child Care Center (PCCC) without having a license. A license shall be issued only to the applicant named and for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the PCCC.
- (2) In order to make application for a license:
  - (a) The applicant shall submit an application on a form prepared by the department.
  - (b) Each applicant for a license, with the exception of the U.S. Government, the State of Tennessee or local government, shall pay an annual license fee in the amount of one thousand eighty dollars (\$1,080.00). The fee must be submitted with the application and is not refundable.
  - (c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. No child shall be admitted to the PCCC until a license has been issued. Applicants shall not hold themselves out to the public as being a PCCC until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules and regulations including submission of all information required by T.C.A. §68-11-206(a)(1), or as later amended, and of all information required by the Commissioner.
  - (d) The applicant must prove the ability to meet the financial needs of the facility.
  - (e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.
- (3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(Rule 1200-8-2-.02, continued)

- (a) For the purposes of licensing, the licensee of a PCCC has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the PCCC operation is transferred.
  - (b) A change of ownership occurs whenever there is a change in the legal structure by which the PCCC is owned and operated.
  - (c) Transactions constituting a change of ownership include, but are not limited to, the following:
    - 1. Transfer of the facility's legal title;
    - 2. Lease of the facility's operations;
    - 3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;
    - 4. One partnership is replaced by another through the removal, addition or substitution of a partner;
    - 5. Removal of the general partners or general partner, if the facility is owned by a limited partnership;
    - 6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are cancelled;
    - 7. The consolidation of a corporate facility owner with one or more corporations; or,
    - 8. Transfer between levels of government.
  - (d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:
    - 1. Changes in the membership of a corporate board of directors or board of trustees;
    - 2. Two (2) or more corporations merge and the originally licensed corporation survives;
    - 3. Changes in the membership of a non-profit corporation;
    - 4. Transfers between departments of the same level of government; or,
    - 5. Corporate stock transfers or sales, even when a controlling interest.
  - (e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.
  - (f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the exact same legal form as the former owner.
- (4) To be eligible for license or renewal of a license, each PCCC shall be periodically inspected for compliance with these regulations. If deficiencies are identified, an acceptable plan of correction must be submitted.

(Rule 1200-8-2-.02, continued)

- (5) All PCCC's may maintain certification as a Community Health Clinic (see Chapter 1200-13-2, Tennessee Department of Health) and as a Comprehensive Outpatient Rehabilitation Facility (see 42 U.S.C. 1395x(cc) of the Social Security Act and Subpart B of 42 Code of Federal Regulations [CFR] Part 485).

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, and 68-11-216.

**Administrative History:** Original rule certified June 7, 1974. Amendment filed July 3, 1984; effective August 1, 1984. Repeal and new rule filed May, 22, 1986; effective July 21, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed April 1, 1992; effective May 16, 1992. Amendment filed November 3, 1992; effective December 18, 1992. Amendment filed March 7, 1994; effective May 21, 1994. Amendment filed December 30, 1994; effective March 18, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal filed March 18, 2000; effective May 30, 2000. New rule filed June 13, 2002; effective August 27, 2002. Amendment filed January 19, 2007; effective April 4, 2007.

### **1200-8-2-.03 DISCIPLINARY PROCEDURES.**

- (1) The board may suspend or revoke a license for:
  - (a) Violation of federal or state statutes;
  - (b) Violation of the rules as set forth in this chapter;
  - (c) Permitting, aiding or abetting the commission of any illegal act in the PCCC;
  - (d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the children in the PCCC; and
  - (e) Failure to renew license.
- (2) The board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:
  - (a) The degree of sanctions necessary to ensure immediate and continued compliance;
  - (b) The character and degree of impact of the violation on the health, safety and welfare of the children in the PCCC;
  - (c) The conduct of the PCCC in taking all feasible steps or procedures necessary or appropriate to comply or correct the violations; and
  - (d) Any prior violations by the PCCC of statutes, regulations or orders of the board.
- (3) When a PCCC is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the deficiencies, the PCCC must return a plan of correction indicating the following:
  - (a) How the deficiency will be corrected;
  - (b) The date upon which each deficiency will be corrected;
  - (c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and
  - (d) How the corrective action will be monitored to ensure that the deficient practice does not recur.



(Rule 1200-8-2-.03, continued)

- (4) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the PCCC license to possible disciplinary action.
- (5) The department may assess a civil penalty not to exceed one thousand dollars (\$1,000) against any person or entity operating a prescribed child care facility without the license required by this chapter or in violation of any other statute or regulation promulgated hereunder. Each day of operation is a separate offense.
  - (a) The board is authorized to conduct contested cases regarding appeals of the penalties assessed pursuant to this subsection.
- (6) Any licensee or applicant for a license, aggrieved by decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, T.C.A. §4-5-101, et seq.
- (7) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, and 68-11-213. **Administrative History:** Original rule certified June 7, 1974. Amendment filed July 3, 1984; effective August 1, 1984. Repeal filed May 22, 1986; effective July 21, 1986. New rule filed June 13, 2002; effective August 27, 2002. Amendment filed March 1, 2007; effective May 15, 2007.

#### **1200-8-2-.04 ADMINISTRATION.**

- (1) The licensee or governing body of the PCCC shall ensure the following:
  - (a) The facility complies with all applicable federal, state, and local laws, ordinances, rules and regulations;
  - (b) The facility is administered and operated in accordance with written policies and procedures;
  - (c) The general direction over the facility and the establishment of policies governing the operation of the facility and the welfare of the children served;
  - (d) That an administrator be designated for the operation of the facility who may be the licensee, or the nursing director.
- (2) A current written policies and procedures manual shall be maintained. The manual must include the following elements:
  - (a) An organizational chart or a statement which clearly shows or describes the lines of authority between the governing body, the administrator, the nursing director, and the staff;
  - (b) A description of facility services provided by the licensee. The description shall include at a minimum the hours of operation and admission and discharge criteria;
  - (c) Exclusion criteria for persons not appropriate for admission;
  - (d) A schedule of fees, if any, currently charged to the parent for all services provided by the licensee;

(Rule 1200-8-2-.04, continued)

- (3) The PCCC must have an effective governing body legally responsible for the conduct of the PCCC. If a PCCC does not have an organized governing body, the persons legally responsible for the conduct of the PCCC must carry out the functions specified in this chapter.
- (4) When licensure is applicable for a particular job, the number and renewal number of the current license must be maintained in personnel. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee.
- (5) Whenever the rules and regulations of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A PCCC that violates a required policy also violates the rule and regulation establishing the requirement.
- (6) No PCCC shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, or the Comptroller of the State Treasury. A PCCC shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.
- (7) Personnel.
  - (a) All PCCC's as defined in §68-11-201 shall initiate a criminal background check on any person who is employed by or who wishes to volunteer in a capacity which involves providing direct care to a child, prior to or within seven (7) days of employment or provision of services. Any person who applies for employment in a position or who wishes to volunteer in a capacity which involves providing direct care to a child in such a facility shall consent to:
    1. Provide past work and personal references to be checked by the PCCC; and/or
    2. Agree to the release of any and all information and investigative records to the PCCC or its agent, or to any agency that contracts with the State of Tennessee necessary for the purpose of verifying whether the individual has been convicted of a felony in the State of Tennessee; and/or
    3. Supply a fingerprint sample and submit to a criminal history records check to be conducted by the Tennessee Bureau of Investigation, other law enforcement agency, or any legally authorized entity; and/or
    4. Release any information required for a criminal background investigation by a professional background screening organization or criminal background check service or registry.
    5. Any cost incurred by the Tennessee Bureau of Investigation, professional background screening organization, law enforcement agency or other legally authorized entity, in conducting such investigations of such applicants or volunteers may be paid by the PCCC, or any agency that contracts with the State of Tennessee requesting such investigation and information, or the individual who seeks employment or is employed or volunteers. Payments of such costs to the Tennessee Bureau of Investigation are to be made in accordance with the provisions of Tennessee Code Annotated, § 38-6-103 and §38-6-109.
    6. A PCCC which declines to employ or terminates a person based upon information provided to the facility under this section shall be immune from suit by or on behalf of that person for the termination of or the refusal to employ that person.

(Rule 1200-8-2-.04, continued)

- (b) A personnel record for each staff member of a facility shall include an application for employment and a record of any disciplinary action taken.
  - (c) Time records, including but not limited to, authorization and record of leave, shall be maintained.
  - (d) A job description shall be maintained which includes the employment requirements and the job responsibilities for each facility staff position.
  - (e) A personnel record shall be maintained which verifies that each employee meets the respective employment requirements for the staff position held, including annual verification of basic skills and annual evaluation of personnel performance. This evaluation shall be in writing. There shall be documentation to verify that the employee has reviewed the evaluation and has had an opportunity to comment on it.
  - (f) Training and development activities which are appropriate in assisting the staff in meeting the needs of the children being served shall be provided for each staff member including STD/HIV education and child abuse education. The provision of such activities shall be evidenced by documentation in the facility's records.
  - (g) Training and development activities which are appropriate in assisting volunteers (if volunteers are used by the facility) in implementing their assigned duties shall be provided for each volunteer. The provision of such activities shall be evidenced by documentation in the facility's records.
  - (h) Direct-services staff members shall be competent persons aged eighteen (18) years of age or older.
  - (i) All new employees, including volunteers, who have routine contact with children shall have a current tuberculosis test prior to employment. (See Appendix C)
  - (j) Employees shall have a tuberculin skin test annually.
  - (k) Employee records shall include date and type of tuberculin skin test used and date of tuberculin skin test results, date and results of chest x-ray, and any drug treatment for tuberculosis.
- (8) Responsibility for Staff
- (a) The licensee of the PCCC is responsible for selecting individuals of suitable character to work with children.
  - (b) All PCCC facilities shall have a minimum full time equivalent staff of one registered nurse. Thereafter, the ratio of staff to children shall be maintained at a ratio of one staff person for every three (3) children.
  - (c) The administrator of the PCCC is responsible for staff and program and the day-to-day operation of the center.
  - (d) A licensed health care professional at the center shall be designated to be in charge in the absence of the administrator.
  - (e) Exclusions for certain activities and crimes:

(Rule 1200-8-2-.04, continued)

1. No person shall be employed, work as a caregiver, or have access to or contact with children in the child care program:
  - (i) who is known to the child care center's management as a perpetrator of child abuse or child sexual abuse; or
  - (ii) who is identified to the child care center's management by the Department of Children's Services as a validated or indicated perpetrator of abuse of a child; or
  - (iii) who is currently charged with, has been convicted of, or pled guilty in any manner to a crime involving a child; or
  - (iv) who has pled guilty to any lesser offense derived from an original offense involving a child; or
  - (v) who is currently charged with, has been convicted of, or who has pled guilty in any manner to a crime of violence against another person, or who has pled guilty to any lesser offense derived from a crime of violence against another person; or
  - (vi) who is currently charged with, who has been convicted of, or who has pled guilty in any manner to, or who has pled guilty to any lesser offense derived from, any offense involving the manufacture, sale, distribution, or possession of any drug; and
  - (vii) who is associated in providing care or ancillary services in any manner within a child care program; or
  - (viii) who is a family member or other person residing at the child care center's facility or adjacent residence; or
  - (ix) who has unrestricted access to children in the facility.
2. An employee or volunteer who has been identified by the Department as having neglected a child based on an investigation conducted by the Department of Children's Services pursuant to a report of harm, and who has not been criminally charged or convicted or pled guilty as stated above, shall be supervised by another adult while providing care for children.
3. Exceptions may be granted on a case-by-case basis by the Department in its sole discretion to persons subject to items 1. (iii), (iv), and (v) in situations where the person is charged with, has pled guilty to, or has been convicted of a crime involving accidental or negligent acts rising to the level of a criminal charge. Exceptions are granted subject to the availability of documentation necessary to make a determination. The criteria which will be considered include, but are not limited to:
  - (i) The act did not rise above the level of criminally negligent homicide or vehicular homicide and did not include the use of drugs or alcohol;
  - (ii) The act was isolated and was not consistent with the person's usual character;
  - (iii) The circumstances were not related to the provision of child care;
  - (iv) The circumstances do not reflect the inability to provide child care by the affected person in any manner inconsistent with these rules.

(Rule 1200-8-2-.04, continued)

- (f) The behavior of staff shall reflect knowledge and understanding of the special needs, growth, and developmental patterns of young children and understanding of appropriate activities, as reflected in staff's performance evaluations.
- (9) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:
  - (a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;
  - (b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and
  - (c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-234, and 71-6-121. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002. Amendment filed April 17, 2007; effective July 1, 2007. Amendment filed July 18, 2007; effective October 1, 2007.

#### **1200-8-2-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.**

- (1) The intake and assessment process shall include the following:
  - (a) The information to be obtained on all children or referrals for admission;
  - (b) The procedures for accepting referrals from outside agencies or organizations;
  - (c) The records to be kept on all children;
  - (d) Any prospective child data to be recorded during the intake process; and
  - (e) The procedures to be followed when a child or a referral is found eligible for admission.
- (2) Admission of Children and Communication with Parents
  - (a) Infants and children considered for admission to the PCCC facility shall be those with complex medical conditions requiring continual care, including, but not limited to:
    - 1. supplemental oxygen;
    - 2. ventilator dependence;
    - 3. cystic fibrosis;
    - 4. apnea; and
    - 5. spinal cord injury and malignancy.

(Rule 1200-8-2-.05, continued)

- (b) The child shall not present significant risk to the health and safety of other children or personnel that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.
- (c) The child shall be medically stabilized, require skilled nursing care, and/or other interventions, and be appropriate for outpatient care.
- (d) Prior to placement, pre-admission planning conferences shall be held for the purpose of developing a plan of care.
- (e) The plan of care shall be developed under the direction of the PCCC nursing director and shall specify the treatment plan needed to accommodate the medical, nursing, psychological, and developmental needs of the child and family. The educational needs of the child shall be coordinated with appropriate local public school system personnel. Specific goals for care shall be identified. Plans for achieving the goals shall be determined and a schedule for evaluation of progress will be established.
- (f) The plan shall be signed by the authorized representative of the PCCC, physician, and parent(s). Copies of the plan shall be given to the parent(s) and the PCCC staff.
- (g) A consent form, outlining the purpose of a PCCC facility, family responsibilities, authorized treatment, and emergency disposition plans shall be signed by the parent(s) and witnessed prior to admission to the PCCC facility. The original consent form shall be retained by the facility. The parent(s) shall be provided a copy of the consent form.
- (h) At the time of admission, written policies and procedures of the PCCC shall be provided to parents or other applicants. Policies shall include criteria for dismissal of children. A copy of PCCC policies and procedures shall be given to the parent and documentation of receipt filed in the child's record.
- (i) A pre-enrollment visit to the center by the parent shall be documented.
- (j) Upon enrollment of a child, the parent shall receive a summary of the Department's licensing requirements and receipt of the summary shall be documented by the parent's signature.
- (k) Each PCCC shall develop a plan for regular and ongoing communication with parents. This plan shall include communication concerning curriculum, changes in personnel, or planned changes affecting children's routine care. Documentation shall be maintained for the most recent quarter.
- (l) During normal operating hours, parents shall be permitted access to their children, and ready access to all areas of the PCCC shall be granted Department representatives and inspection authorities (i.e., fire safety, sanitation, and health).
- (m) Parents shall be informed in advance of the child's removal from the premises except in cases of emergencies or pursuant to investigative procedures conducted pursuant to the child abuse laws.
- (n) Children shall not be in care for more than sixteen hours in a twenty-four hour period except in special circumstances (e.g., acute illness of or injury to parents, natural disaster, unusual work hours). Individual plans for extended care shall be maintained, with documentation, signed by parent and administrator, retained on file.
- (o) Part-time children shall be counted in the ratio and group and shall have required records on file before they are cared for.

(Rule 1200-8-2-.05, continued)

- (p) Any infant or child not meeting the criteria set out in 1200-8-2-.05(2)(a)-(c) shall be discharged from the PCCC.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002.

#### **1200-8-2-.06 BASIC SERVICES.**

##### **(1) Nursing Services.**

- (a) The PCCC must have an organized nursing service that provides twenty-four (24) hour nursing services furnished or supervised by a registered nurse. A registered nurse must be on the premises at all times during business hours.
- (b) The PCCC must have a well-organized service with a plan of administrative authority and delineation of responsibilities for child care. The nursing director must be a licensed registered nurse who is responsible for the operation of the nursing service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for the PCCC.
- (c) The nursing service must have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care to all children as needed. There must be supervisory and staff personnel for each department or unit of the PCCC to ensure, when needed, the immediate availability of a registered nurse.
- (d) There must be a procedure to ensure that nursing personnel for whom licensure is required have valid and current licenses.
- (e) A registered nurse must assess, supervise and evaluate the nursing care for each child.
- (f) The PCCC must ensure that an appropriate individualized plan of care is prepared for each child.
- (g) A registered nurse must assign the nursing care of each child to other nursing personnel in accordance with the child's needs and the specialized qualifications and competence of the nursing staff available. All nursing personnel shall have specialized training and a program in-service and continuing education commensurate with the duties and responsibilities of the individual. All training shall be documented for each individual so employed, along with documentation of annual competency skills. Orientation of any new personnel must be conducted within the first two weeks of employment.
- (h) Non-employee licensed nurses who are working in the PCCC must adhere to the policies and procedures of the facility. The nursing director must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service. Annual competency and skill documentation must be demonstrated on these individuals just as on employees, if they perform clinical activities.
- (i) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements.
- (j) All orders for drugs, devices and related materials must be in writing and signed by the practitioner or practitioners responsible for the care of the child. Electronic and computer-

(Rule 1200-8-2-.06, continued)

generated records and signature entries are acceptable. When telephone or oral orders must be used, they must be:

1. Accepted only by personnel that are authorized to do so by policies and procedures, consistent with federal and state law; and
  2. Signed or initialed by the prescribing practitioner according to policy.
- (k) Intravenous medications must be administered in accordance with state law and approved policies and procedures.
- (l) There must be a procedure for reporting adverse drug reactions and errors in administration of drugs.
- (2) Physician Services.
- (a) Policies and procedures concerning services provided by the PCCC shall be available to the children's primary care physicians as requested.
  - (b) If children with mental, physical or other impairments or with a medical disorder are enrolled, and special care is needed, a physician's statement shall identify the condition and give the appropriate care professional special instructions for the child's care.
  - (c) Children shall be aided in receiving dental care as deemed necessary.
  - (d) Consultation with a physician shall occur at least annually to review medical care provided within the PCCC and shall include, but not be limited to:
    1. Evaluate the delivery of emergency and medical care when the child's primary physician or his/her designated alternative is unavailable;
    2. Review reports of accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator;
    3. Review performance improvement, infection control and safety action plans for appropriate actions;
    4. Monitor the health status of facility personnel to ensure that no health conditions exist which would adversely affect children; and
    5. Advise and provide consultation on matters regarding medical care, standards of care, surveillance and infection control.
- (3) Educational Services
- (a) The PCCC will provide parent(s) education services by including them in care related conferences and teaching them how to perform necessary therapies and how to meet the developmental and psychological needs of their child at home.
  - (b) Monthly educational development programs shall be conducted and documented. These programs shall be provided to:
    1. Develop collaborative relationships between health professionals and parent(s).



(Rule 1200-8-2-.06, continued)

2. Increase understanding and coping with the effects of childhood illness, and shall cover a variety of topics including:
    - (i) issues of death and dying;
    - (ii) awareness of services available;
    - (iii) fostering of advocacy skills;
    - (iv) impact of illness on child development; and
    - (v) parenting an ill child.
  3. Develop case management skills to assist the family in setting priorities and planning and implementing the child's care at home.
  4. Develop a comprehensive Plan of Care to include the medical, nutritional, developmental and psychosocial needs of medically/technologically dependent children, including training in the implementation of new technology.
  5. Prepare for management of emergency medical situations.
- (c) A comprehensive orientation to acquaint the parent(s) with the philosophy and services of the PCCC shall be provided at the time of the child's placement in the PCCC.
  - (d) Activities shall be used for the children based on developmentally appropriate educational practices.
  - (e) To the extent that children are physically able to participate, a daily program shall provide opportunities for learning, self-expression, and participation in a variety of creative activities such as art, music, literature, dramatic play, science and health.
  - (f) Indoor physical activities, requiring children to use both large and small muscles, shall be provided for children of each age group who are physically able to participate.
  - (g) Activities for infants/toddlers shall provide experience for the development of language, gross motor, fine motor, social/personal, cognitive, and self-help skills. Examples of such activities include music, dramatic play, story-time, free activity periods, outdoor play, and the opportunity to explore many materials, situations, and roles.
  - (h) Because of the importance of language development and communication skills to infants and toddlers, they shall be talked to, listened to, read to and sung to, in addition to other language experience activities, including but not limited to, finger plays, patty cake, and flannel board activities.
- (4) Nutritional Services
    - (a) The PCCC must have an organized dietary service that is directed and staffed by adequate qualified personnel. A facility may contract with an outside food management company if the company has a dietitian who serves the facility on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this paragraph and provides for consultant liaison with the facility staff for recommendations on dietetic policies affecting the children's treatment. If an outside contract is utilized for management of its dietary services, the facility shall designate a full-time employee to be responsible for the overall management of the services.

(Rule 1200-8-2-.06, continued)

- (b) The PCCC must designate a person, either directly or by contractual agreement, to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be:
  - 1. A qualified dietitian; or,
  - 2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or,
  - 3. A graduate of a state-approved course that provided ninety (90) or more hours of classroom instruction in food service supervision and who has experience as a food service supervisor in a health care institution with consultation from a qualified dietitian.
- (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis, who is responsible for the development and implementation of a nutrition care process to meet the needs of health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the child and treatment through diet therapy, counseling and/or use of specialized nutrition supplements.
- (d) Menus must meet the needs of the children.
  - 1. Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the children and must be prepared and served as prescribed.
  - 2. Special diets shall be prepared and served as ordered.
  - 3. Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the children.
  - 4. A current therapeutic diet manual approved by the dietitian and nursing director must be readily available to all nursing and food service personnel.
- (e) Educational programs, including orientation, on-the-job training, inservice education, and continuing education, shall be offered to dietetic services personnel on a regular basis. Programs shall include instruction in the use of equipment, personal hygiene, proper inspection, and the handling, preparing and serving of food.
- (f) A minimum of three (3) meals in each twenty-four (24) hour period shall be served. A supplemental night meal shall be served if more than fourteen (14) hours lapse between supper and breakfast. Additional nourishment shall be provided to children with special dietary needs. A minimum of three (3) days supply of food shall be on hand.
- (g) Menus shall be prepared at least one week in advance. A dietitian shall be consulted to help write and plan the menus. If any change in the actual food served is necessary, the change shall be made on the menu to designate the foods actually served to the children. Menus of food served shall be kept on file for a thirty (30) day period.
- (h) The dietician or designee shall have a conference, dated on the medical record with each child and/or family within two (2) weeks of admission to discuss the diet plan indicated by the physician. The child's dietary preferences shall be recorded and utilized in planning his/her daily menu.

(Rule 1200-8-2-.06, continued)

- (i) Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways.
- (j) Perishable food shall not be allowed to stand at room temperature except during necessary periods of preparation or serving. Prepared foods shall be kept hot (140°F or above) or cold (45°F or less). Appropriate equipment for temperature maintenance, such as hot and cold serving units or insulated containers, shall be used.
- (k) Food shall not be forced on or withheld from children. Food shall not be used as a reward, nor shall food be used or withheld as punishment.
- (l) Specific feeding instructions given by parents shall be in writing. If staff feel instructions to be inappropriate or in conflict with established policy or the therapeutic diet prescribed by the practitioner, staff shall initiate discussion with the parent to resolve the conflict.
- (m) New foods shall be introduced to infants and toddlers; foods shall be introduced one at a time over a five-to-seven day period with parental approval.
- (n) The feeding schedule for infants shall be in accordance with the child's need rather than according to the hour. (Infants fed breast milk may require more frequent feedings than formula-fed babies.)
- (o) Parents and caregivers shall work together when weaning an infant to insure consistency in the weaning process. Weaning shall be delayed until after an infant adjusts to group care.
- (p) Children shall not be permitted to carry a bottle with them throughout the day.
- (q) All formulas and food brought from home shall be labeled with child's name. Milk shall be placed immediately in the refrigerator. Once milk has been warmed, it shall not be rewarmed or returned to the refrigerator. For optimum digestion, formula is to be served at body temperature.
- (r) Frozen breast milk shall be dated when expressed. Bottled breast milk shall not be heated in a microwave oven. To prevent scalding, extreme caution shall be taken when a microwave oven is used to heat food.
- (s) Previously opened baby food jars shall be not accepted in the PCCC.
- (t) Infants shall be held while being fed if they are unable to sit in a high chair, an infant seat, or at the table. Bottles shall not be propped. A child shall not be given a bottle while lying flat.
- (u) When children are capable of using a high chair, they shall be allowed to do so and to experiment with food, with feeding themselves, and to eat with fingers or spoon. Children shall not be left unattended while eating.
- (v) Dishwashing machines shall be used according to manufacturer specifications.
- (w) All dishes, glassware and utensils used in the preparation and serving of food and drink shall be cleaned and sanitized after each use.
- (x) The cleaning and sanitizing of handwashed dishes shall be accomplished by using a three-compartment sink according to the current "U.S. Public Health Services Sanitation Manual":

(Rule 1200-8-2-.06, continued)

- (y) The kitchen shall contain sufficient refrigeration equipment and space for the storage of perishable foods.
  - (z) All refrigerators and freezers shall have thermometers. Refrigerators shall be kept at a temperature not to exceed 45<sup>0</sup>F. Freezers shall be kept at a temperature not to exceed 0<sup>0</sup>F.
  - (aa) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the “U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking Establishments”, and the current “U.S. Public Health Service Sanitation Manual” should be used as a guide to food sanitation.
- (5) Pharmaceutical Services.
- (a) The PCCC shall have pharmaceutical services that meet the needs of the children and are in accordance with the Tennessee Board of Pharmacy statutes and rules. The administrator is responsible for developing policies and procedures that minimize drug errors.
  - (b) All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms. Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons. Poisons or external medications shall not be stored in the same compartment and shall be labeled as such.
  - (c) Schedule II drugs must be stored behind two (2) separately locked doors at all times and accessible only to persons in charge of administering medication.
  - (d) Every PCCC shall comply with all state and federal regulations governing Schedule II drugs.
  - (e) A notation shall be made in a Schedule II drug book and in the child’s medical chart each time a Schedule II drug is given. The notation shall include the name of each child receiving the drug, name of the drug, the dosage given, the method of administration, the date and time given and the name of the physician prescribing the drug.
  - (f) All oral orders shall be immediately recorded, designated as such and signed by the person receiving them and countersigned by the physician within ten (10) days.
  - (g) All orders for drugs, devices and related materials must be in writing and signed by the practitioner or practitioners responsible for the care of the child. Electronic and computer-generated records and signature entries are acceptable. When telephone or oral orders must be used, they shall be:
    - 1. Accepted only by personnel that are authorized to do so by policies and procedures, consistent with federal and state law; and,
    - 2. Signed or initialed by the prescribing practitioner according to policy.
  - (h) Medications not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies. No Schedule II drug shall be given or continued beyond seventy-two (72) hours without a written order by the physician.
  - (i) Medication administration records (MAR) shall be maintained for each child. Each dose shall be properly recorded in the medical record after it has been administered.

(Rule 1200-8-2-.06, continued)

- (j) Preparation of doses for more than one scheduled administration time shall not be permitted.
  - (k) Medication shall be administered only by licensed medical or nursing personnel or other licensed health professionals acting within the scope of their licenses.
  - (l) Unless the unit dose package system is used, individual prescriptions of drugs shall be kept in the original container with the original label intact showing the name of the child, the drug, the physician, the prescription number and the date dispensed.
  - (m) Legend drugs shall be dispensed by a licensed pharmacist.
  - (n) Any unused portions of prescriptions shall be turned over to the parent(s) or only on discharge. A notation of drugs released shall be entered into the medical record. All unused prescriptions not taken by the parent and left at the PCCC must be destroyed on the premises and recorded by a pharmacist. Such record shall be kept in the PCCC.
- (6) Rehabilitation Services.
- (a) Physical therapy, occupational therapy and speech therapy shall be provided directly or through contractual agreement by individuals who meet the qualifications specified by PCCC policy and consistent with state law.
  - (b) A licensed physical therapist shall be in charge of the physical therapy service and a licensed occupational therapist shall be in charge of the occupational therapy service.
  - (c) Direct contact shall exist between the child and the therapist for those children that require treatment ordered by a physician.
  - (d) If ordered by a physician, the physical therapist and the occupational therapist shall provide treatment and training designed to preserve and improve abilities for independent functions, such as: range of motion, strength, tolerance, coordination and activities of daily living.
  - (e) Therapy services shall be coordinated with the nursing service and made a part of the child's treatment plan.
  - (f) Sufficient staff shall be made available to provide the service ordered.
- (7) Psychologist/Social Work Services.
- (a) Social services and psychological services must be available to the children, the child's family and other persons significant to the child, in order to facilitate adjustment of these individuals to the impact of the child's illness and to promote maximum benefits from the health care services provided.
  - (b) Social work services shall include psychosocial assessment, counseling, coordination of discharge planning, community liaison services, financial assistance and consultation.
  - (c) Psychological services shall include psychoanalysis, psychotherapy, psychological testing, psychoeducational evaluation therapy remediation and consultation.
  - (d) A child's social history shall be obtained within two (2) weeks of admission and shall be appropriately maintained.
  - (e) Social work services shall be provided by a qualified social worker.

(Rule 1200-8-2-.06, continued)

- (f) Facilities for social work services shall be readily accessible and shall permit privacy for interviews and counseling.
- (8) Respiratory Care Services (Optional).
  - (a) If the PCCC provides respiratory care services, the PCCC must meet the needs of the patients in accordance with acceptable standards of practice.
  - (b) The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.
  - (c) There must be adequate numbers of licensed respiratory therapists, respiratory technicians, and other personnel to provide the ordered services.
  - (d) Services must be delivered in accordance with physician directives.
  - (e) Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.
- (9) Infection Control.
  - (a) The PCCC must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.
  - (b) The administrator shall assure that an infection control program, including members of the multidisciplinary staff such as nursing and administrative staff, develop guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the program shall include the establishment of:
    - 1. Written infection control policies;
    - 2. Techniques and systems for identifying, reporting, investigating and controlling infections in the facility;
    - 3. Written procedures governing the use of aseptic techniques and procedures in the facility;
    - 4. Written procedures concerning food handling, laundry practices, disposal of environmental and human wastes, traffic control and visiting rules, sources of air pollution, and routine culturing of autoclaves and sterilizers;
    - 5. A log of incidents related to infectious and communicable diseases;
    - 6. Formal provisions to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing, proper grooming, masking, dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of equipment and supplies; and,
    - 7. Continuing education for all facility personnel on the cause, effect, transmission, prevention, and elimination of infections.
  - (c) The administrator must ensure that the facility-wide performance improvement program and training programs address problems identified by the infection control program and must be

(Rule 1200-8-2-.06, continued)

responsible for the implementation of successful corrective action plans in affected problem areas.

- (d) Parents of every child enrolled shall be notified immediately if one of the following communicable diseases has been introduced into the child care center: hepatitis A, foodborne outbreaks (food poisoning) salmonella, shigella, measles, mumps, rubella, pertussis, polio, haemophilus influenza type B, meningococcal meningitis. The PCCC shall report the occurrence of the above diseases to the local health department.
  - (e) Impetigo and diagnosed strep shall be treated appropriately for 24 hours prior to readmission to the center. Children having scabies or lice shall have proof of treatment to be readmitted. The PCCC shall provide care and/or isolation for a child with a contagious condition only if written instructions of a licensed physician or certified health care provider are obtained first.
  - (f) The PCCC shall develop policies and procedures for testing a child's blood for the presence of the hepatitis B virus and the HIV virus in the event that an employee of the facility, a student studying at the facility, or other health care provider rendering services at the facility is exposed to a child's blood or other body fluid. The testing shall be performed at no charge to the child and the test results shall be confidential.
  - (g) The facility and its employees shall adopt and utilize standard or universal precautions of the Centers for Disease Control (CDC) for preventing transmission of infections, HIV, and communicable diseases.
  - (h) All PCCCs shall adopt appropriate policies regarding the testing of children and staff for HIV and any other identified causative agent of acquired immune deficiency syndrome.
  - (i) Precautions shall be taken to prevent the contamination of sterile supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents. Decontamination and preparation areas shall be separated.
  - (j) Space and facilities for housekeeping equipment and supplies shall be provided in each service area. Storage for bulk supplies and equipment shall be located away from child care areas. The building shall be kept in good repair, clean, sanitary and safe at all times.
- (10) Performance Improvement.
- (a) The PCCC must ensure that there is an effective, facility-wide performance improvement program to evaluate child care and performance of the organization.
  - (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that:
    - 1. All organized services related to child care, including services furnished by a contractor, are evaluated;
    - 2. Nosocomial infections and medication therapy are evaluated; and,
    - 3. All services performed in the facility are evaluated as to the appropriateness of diagnosis and treatment.
  - (c) The PCCC must have an ongoing plan, consistent with available community and facility resources, to provide or make available services that meet the medically-related needs of its children.

(Rule 1200-8-2-.06, continued)

- (d) The facility must develop and implement plans for improvement to address deficiencies identified by the performance improvement program and must document the outcome of the remedial action.
  - (e) Performance improvement program records shall be disclosable to the Department to demonstrate compliance with this section.
  - (f) Good faith attempts by the performance improvement program committee to identify and correct deficiencies will not be used as a basis for sanctions.
- (11) Transportation Services (If Provided)
- (a) If a PCCC provides transportation, its management shall recognize its full responsibility for the child between home and facility and on field trips. On field trips or when transporting children between home and the facility, staff shall maintain an accurate list of children being transported and shall take roll frequently. The driver or accompanying staff member shall assure that every child is received by a parent or other designated person. The owner of the vehicle shall carry adequate liability insurance.
  - (b) Parents shall be notified of each field trip and notification documented.
  - (c) Vehicles used to transport children shall be maintained in safe working condition. Regular scheduled inspections shall be documented. Documentation of regular maintenance shall be kept on file in the facility. (See Appendix A)
  - (d) The driver shall comply with the health requirements as specified in Appendix C of these Rules.
  - (e) On field trips off premises, at least two (2) adults shall be in the vehicle, in addition to the driver.
  - (f) Children shall always be attended by a licensed nurse while in a vehicle.
  - (g) The number of infants and other non-ambulatory children transported by one licensed nurse shall be limited to six. A second licensed nurse shall be in the vehicle supervising the children when seven or more children are being transported.
  - (h) Transportation provided by the PCCC or under PCCC auspices shall comply with state law.
  - (i) All children and the driver shall be secured in individual passenger restraint devices at all times during the transportation by the PCCC or under PCCC auspices. Exception: Children four (4) years of age and older transported by a school bus or public transportation are not required to be restrained because these vehicles are not required to be equipped with restraint devices.
  - (j) No child shall be allowed to ride on the floor of a vehicle, and no child shall be placed with another child in the same restraint device.
  - (k) Drivers of any vehicle used to transport children shall have a proper license and endorsement required for the transportation of the number of passengers transported and the vehicle size and weight as required in Chapter 50 of Title 55 of the Tennessee Code Annotated.
  - (l) A vehicle used to transport children shall have fire extinguishers, emergency reflective triangles, a first aid kit and a blood-borne pathogenic clean-up kit, and an adult familiar with the use of this equipment on board. Emergency exiting procedures shall be practiced by all staff responsible for transporting children on a regular basis.



(Rule 1200-8-2-.06, continued)

- (m) Storage of firearms is prohibited in vehicles used to transport children.
  - (n) A minimum of ten (10) inches seat space per child is required in a vehicle transporting children.
  - (o) Children shall not spend more than ninety (90) minutes traveling one way.
- (12) Recreational Services.
- (a) The PCCC shall provide opportunities for recreational activities appropriate to the needs, interests, and ages of the children being served.
  - (b) Equipment needs for Children:
    - 1. General
      - (i) All indoor and outdoor equipment shall be well made and safe. There shall be no dangerous angles, no sharp edges, splinters, or nails sticking out, no open S-hooks or pinch points within children's reach.
      - (ii) Damaged equipment shall be repaired or removed from the room or playground immediately.
      - (iii) Equipment shall be kept clean by washing frequently with soap and water.
      - (iv) There shall be developmentally appropriate equipment and furnishings for each age group in attendance.
      - (v) Material and equipment shall be provided to meet the needs of all the children enrolled.
      - (vi) Individual lockers, separate hooks and shelves or other containers (placed at children's reaching level for mobile children) shall be provided for each child's belongings.
    - 2. Indoor Play Equipment
      - (i) Pieces of equipment, such as television sets, bookcases and appliances, shall be secured or supported so that they will not fall or tip over.
      - (ii) Indoor equipment, materials, and toys shall be available to:
        - (I) Meet active and quiet play needs of all children enrolled;
        - (II) Provide a variety of developmentally appropriate activities so that each child has at least three choices during play time; and
        - (III) Adequately provide for all the activities required in other sections of this rule.
      - (iii) Toys, educational and play materials shall be organized and displayed within children's reach so that, if physically able, they can select and return items independently.
      - (iv) Teaching aids that are small or that have small parts that can be inhaled or swallowed shall be inaccessible to infants and toddlers.

(Rule 1200-8-2-.06, continued)

3. Outdoor Play Equipment (Optional)

- (i) All outdoor play equipment shall be sufficient in amount and variety so that children can take part in many kinds of play each day.
- (ii) The Consumer Products Safety Commission's "Handbook on Public Playground Safety" or similar authority shall be used for guidance on playground construction and maintenance.
- (iii) All outdoor play equipment shall be placed to avoid injury. Fall zones shall extend at least four (4) feet and preferably six (6) feet away from the perimeter of equipment and away from retainer structures, fences, and other equipment and out of children's traffic paths.
- (iv) Resilient surfacing material shall cover fall zones at a recognized acceptable depth. (See Appendix B)
- (v) Supports for climbers, swings, and other heavy equipment that could cause injury if toppled shall be securely anchored to the ground, even if the equipment is designed to be portable.

(13) Environmental Services.

- (a) Environmental services shall be provided to assure the clean and sanitary condition of the PCCC and to provide a safe and hygienic environment for children and staff. Cleaning shall be accomplished in accordance with the infection control rules and regulations herein and PCCC policy; and
- (b) There shall be verification of regular continuing education and competency for basic housekeeping principles.
- (c) Each facility shall have routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supplies, exhaust, grills and lighting fixtures.
- (d) Sufficient and proper cleaning supplies and equipment shall be available to housekeeping staff. Cleaning supplies, toxic substances and equipment shall be secured at all times to prevent access by children. Toxic substances shall not be left unattended when not secured.
- (e) A closet for janitorial supplies shall be provided.
- (f) Storage for bulk supplies and equipment shall be located away from child care areas. Storage shall not be allowed in the outmost shipping carton.
- (g) The building shall be kept in good repair, clean, sanitary and safe at all times.

(14) Laundry Services.

- (a) Laundry services shall:
  - 1. Provide space for storage of clean linen within nursing units and for bulk storage within clean areas of the PCCC; and

(Rule 1200-8-2-.06, continued)

2. Provide carts, bags or other acceptable containers appropriately marked to identify those used for soiled linen and those used for clean linen to prevent dual utilization of the equipment and cross contamination.
- (b) The PCCC shall name an individual who is responsible for laundry service. This individual shall be responsible for:
  1. Establishing a laundry service, either within the PCCC or by contract, that provides the facility with sufficient clean, sanitary linen at all times;
  2. Knowing and enforcing infection control rules and regulations for the laundry service;
  3. Assuring the collection, packaging, transportation and storage of soiled, contaminated, and clean linen is in accordance with all applicable infection control rules and procedures; and,
  4. Assuring that a contract laundry service complies with all applicable infection control rules and procedures.

**Authority:** §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-21, and 68-11-222. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002.

#### **1200-8-2-.07 BUILDING STANDARDS.**

- (1) The prescribed child care center must be constructed, arranged, and maintained to ensure the safety of the children.
- (2) The condition of the physical plant and the overall prescribed child care center environment must be developed and maintained in such a manner that the safety and well-being of the children are assured.
- (3) When construction is planned by a facility for any building, additions to an existing building or substantial alterations to an existing building, two (2) sets of plans and specifications shall be submitted to the department to be approved. For the purpose of life safety, prescribed child care centers are required to meet business occupancies and all new centers shall conform to the current addition of the Standard Building Code, the National Fire Protection Code (NFPA), and the National Electrical Code, as adopted by the Board for Licensing Health Care Facilities. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.).
- (4) Flammable and combustible liquids such as gasoline, cleaning fluids, kerosene, turpentine etc., shall be stored in safety containers and stored at least 16 feet from the building or stored in a U.L. approved/listed cabinet and ventilated as prescribed by code requirement or manufacturers' recommendation.
- (5) Mechanical
  - (a) All units having a total of 2,000 cubic feet per minute (CFM) or greater in a zone shall shut down when the fire alarm panel is activated.
- (6) Electrical
  - (a) The electrical system, components, equipment and appliances shall be kept in good repair at all times.
  - (b) Knob and Tube wiring is prohibited.

(Rule 1200-8-2-.07, continued)

- (c) Electrical cords shall not have splices.
  - (d) Electric circuit breaker panel boxes shall not have open slots exposing wiring.
  - (e) Circuit breakers shall be properly labeled.
  - (f) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshall.
  - (g) The electrical system shall not be overloaded.
  - (h) Ground-Fault Circuit Interrupters (GFCI) are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc. and within six (6) feet of any laboratory.
- (7) Fire Alarm
- (a) Manual pull stations shall be installed in paths of travel to exits and by each required exit.
  - (b) All alarm devices shall be connected to the fire alarm panel.
  - (c) The fire alarm panel shall have auxiliary power such as batteries or generators.
  - (d) All sprinkler systems are to be electrically supervised.
  - (e) Structures with atriums, vertical openings or monumental stairs open to another floor must have their fire alarm system automatically transmit an alarm to the municipal fire department or to an agency acceptable to this department with equipment which meets NFPA signaling and standard building codes. Fire protection systems and smoke evacuation systems must be on emergency power.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002. Amendment filed February 18, 2003; effective May 4, 2003. Amendment filed June 21, 2007; effective September 4, 2007.

**1200-8-2-.08 LIFE SAFETY.**

- (1) Any prescribed child care center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.
- (2) The prescribed child care center shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Records which document and evaluate these incidents must be maintained for at least three (3) years.
- (3) The prescribed child care center shall have a written emergency plan to document instructions to staff, upon employment, and clients, upon enrollment, in fire evacuation procedures. The plan shall include actions to be taken in inclement weather and internal and external emergencies. Evacuation plans shall be posted in prominent areas such as reception areas, near door in class rooms, etc. and shall designate meeting places outside the building in event of emergencies.
- (4) Corridor doors shall not have louvers.

(Rule 1200-8-2-.08, continued)

- (5) Battery powered emergency lighting shall be installed in corridors, common areas and in stair ways.
- (6) Corridors shall be lighted at all times, to a minimum of one foot candle.
- (7) Corridors and exit doors shall be kept clear of equipment, furniture and other obstacles at all times. There shall be a clear passage at all times from the exit doors to a safe area.
- (8) Corridors in multi-storied buildings shall have two exits remote from each other. At least one exit shall be directly to the outside.
- (9) Storage beneath any stair is prohibited.
- (10) Combustible finishes and furnishings shall not be used.
- (11) Open flame and portable space heaters shall not be permitted in the facility. Cooking appliances other than microwave ovens shall not be allowed in the facility.
- (12) All heaters shall be guarded and spaced to prevent ignition of combustible material and accidental burns. The guard shall not have a surface temperature greater than 120°F.
- (13) Fireplaces and/or fireplace inserts may be used only if provided with guards or screens which are secured in place. Fireplaces and chimneys shall be inspected and cleaned annually and verified documentation shall be maintained.
- (14) All electrical equipment shall be maintained in good repair and in safe operating condition.
- (15) Electrical cords shall not be run under rugs or carpets.
- (16) The electrical systems shall not be overloaded. Power strips must be equipped with circuit breakers. Extension cords shall not be used.
- (17) Fire extinguishers, complying with NFPA 10, shall be provided and mounted to comply with NFPA 10. An extinguisher in the kitchen area shall be a minimum of 2-A:10 B:C and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers.
- (18) Smoking and smoking materials shall be permitted only in designated areas. Ashtrays must be provided wherever smoking is permitted. The facility shall have written policies and procedures for smoking within the facility which shall designate a room or rooms to be used exclusively for staff and visitors who smoke. The designated smoking room or rooms shall not be the dining room or activity room.
- (19) Trash and other combustible waste shall not be allowed to accumulate within and around the facility and shall be stored in appropriate containers with tight-fitting lids. Trash containers shall be UL approved.
- (20) All safety equipment shall be maintained in good repair and in a safe operating condition.
- (21) Janitorial supplies shall not be stored in the kitchen, food storage area, dining area or child accessible areas.
- (22) Emergency telephone numbers must be posted near a telephone accessible to the children.

(Rule 1200-8-2-.08, continued)

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002. Amendment filed May 16, 2006; effective July 30, 2006. Amendment filed June 21, 2007; effective September 4, 2007.

#### **1200-8-2-.09 INFECTIOUS AND HAZARDOUS WASTE.**

- (1) Each PCCC must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous wastes. These policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.
- (2) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed of, and how it will be handled and transported prior to treatment and disposal.
- (3) After packaging, waste must be handled and transported by methods ensuring containment and preserving the integrity of the packaging, including the use of secondary containment where necessary.
- (4) Waste must be stored in a manner and location which afford protection from animals precipitation, wind, and direct sunlight, do not present a safety hazard, do not provide a breeding place or food source for insects or rodents and do not create a nuisance.
- (5) In the event of spills, or other incidents where there is a loss of containment of waste, the facility must ensure that proper actions are immediately taken to:
  - (a) Isolate the area;
  - (b) Repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph (4) of this rule; and
  - (c) Sanitize all contaminated equipment and surfaces appropriately.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002.

#### **1200-8-2-.10 RECORDS AND REPORTS.**

- (1) Children's Records.
  - (a) The following records shall be maintained at the PCCC and made available to the Department upon request. Each child shall have a record containing the following information:
    1. A current information form which includes the child's name, date of birth, name of parent(s), child and parent's home address, parent's business address, phone numbers, work hours, social history, and the name and address (home and business or school) of a responsible person to contact in an emergency if parent(s) cannot be located promptly;
    2. Name, address and telephone number of a physician to call in case of an emergency;
    3. Written consent of parent(s) regarding emergency medical care;

(Rule 1200-8-2-.10, continued)

4. A transportation plan, including to whom the child will be released, and a clear policy concerning the release of the child(ren) to anyone whose behavior may place the child(ren) in immediate risk;
5. Comprehensive protocol for care specifying the goals for care and methods for goal achievement and time frame for reviewing and revising the plan;
6. A consent for treatment form signed by parent and PCCC representative;
7. A medical history for the child, including notations from visits to health care providers;
8. Before a preschool child older than eight weeks is accepted for care, he/she shall have proof of being age-appropriately immunized according to the current schedule authorized by the Tennessee Department of Health. (Children six through eight weeks of age may be enrolled before immunizations are begun.)
9. If a child has any known allergies, they shall be indicated in the child's health record. Foreign-born children must also present evidence of tuberculosis screening. (See Appendix C)
10. A copy of each infant/toddler's or preschool child's health history and immunization record, signed or stamped by a certified health care provider, shall be on file in the prescribed child care center and available to the appropriate staff. The health record shall be returned to the parent upon request when the child leaves the center.
11. Exceptions to requirements 8. and 10. of this section may be made only if:
  - (i) The child's physician or the health department provides a signed and dated statement, giving a medical reason why the child should not be given a specified immunization; or
  - (ii) The child's parent provides a signed written statement that such immunizations conflict with his/her religious tenets and practices.
12. Before an infant or toddler is accepted for care, the parent shall have proof of the child's physical examination within three months prior to admission, signed or stamped by a physician or health care provider. Each infant/toddler shall have on file an official health record of the first medical checkup and health history.
13. Other requirements as set forth in Appendix C shall apply.
14. Flow chart of treatments administered;
15. Concise, accurate information and initialed case notes reflecting progress toward plan goal achievement or reasons for lack of progress;
16. Documentation of nutritional management and special diets, as appropriate;
17. Documentation of physical, occupational, speech and/or other special therapies;
18. Daily attendance records for each child;
19. Written permission for field trips away from the premises; and

(Rule 1200-8-2-.10, continued)

20. The same records shall be kept on infants/toddlers as on other children in the PCCC. In addition, each infant's/toddler's and any other non-verbal child's daily activities, including time and amount of feeding, time and amount of medication given, vital signs taken, elimination, times of diaper changes, sleep patterns, and developmental progress shall be recorded and shared with the parent(s) daily.
- (b) A child's records shall be kept for one year following the child's leaving the PCCC. (The health record shall be returned upon request when the child leaves the facility.)
- (c) Unusual incidents shall be reported to the Department within five (5) days of the occurrence of the incident. The Board shall define, identify and establish guidelines for the reporting of an event deemed to be an unusual incident. The facility shall conduct and complete a thorough investigative analysis, which shall include any necessary corrective action, of the incident within 40 days of the occurrence of the incident. The incident report and the investigative analysis report shall be recorded in a format designated by the Department. The investigative analysis report shall remain in the facility. The Department shall have access to the investigative analysis report and any other requested facility record as allowed in T. C. A. 68-11-301 et seq. Access to the investigative analysis report shall not be deemed a waiver of any privilege afforded to the facility. Failure to comply with this sub-paragraph may result in disciplinary action against the facility before the Board.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002.

#### **1200-8-2-.11 CHILD, PARENT OR RESPONSIBLE PARTY'S RIGHTS.**

- (1) The PCCC shall demonstrate respect and support for each child's rights. The facility insures each child receives professional and humanistic services in a manner that protects their fundamental human, civil, constitutional and statutory rights.

Policies and procedures shall be developed, approved, and maintained to ensure consistent application and communication throughout the organization.

- (a) The following rights of children and parents shall apply whenever appropriate:
  1. Impartial access to treatment or accommodations that are available or medically indicated regardless of race, creed, sex, national origin, or sources of payment for care.
  2. Considerate, respectful care at all times and under all circumstances, with recognition of his/her personal dignity, values and beliefs.
  3. Identity and professional status of individuals providing services to the child and to know who is primarily responsible for the child's care or treatment.
  4. Expectation of reasonable safety insofar as family practices and environment are concerned.
  5. Confidentiality of child's records.
  6. Ability to voice complaints regarding care without fear of discrimination or compromising their child's future care.
  7. The parent may direct a determination which encompasses the right to make choices regarding life sustaining treatment, including resuscitative services.



8. Information about fee schedules and payment policies.
  9. Environment conducive to personal and informational privacy.
- (b) Children shall not be abused, neglected, or administered corporal punishment.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002.

#### **1200-8-2-.12 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.**

- (1) Pursuant to this Rule, each prescribed child care center shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a child who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual children. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.
- (2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the patient could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the patient could have made while having capacity.
- (3) The advance directive shall be in writing, signed by the patient, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the child by blood, marriage, or adoption and would not be entitled to any portion of the estate of the child upon the death of the child. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.
- (4) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the patient lacks capacity, and ceases to be effective upon a determination that the patient has recovered capacity.
- (5) A facility shall use the mandatory advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.
- (6) A determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.
- (7) An agent shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the patient's best interest. In determining the patient's best interest, the agent shall consider the patient's personal values to the extent known.
- (8) An advance directive may include the individual's nomination of a court-appointed guardian.
- (9) A health care facility shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the patient's residence.

(Rule 1200-8-2-.12, continued)

- (10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.
- (11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.
- (12) A patient having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.
- (13) A patient having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.
- (14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.
- (15) An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.
- (16) Surrogates.
  - (a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.
  - (b) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if and only if:
    - 1. the patient has been determined by the designated physician to lack capacity, and
    - 2. no agent or guardian has been appointed, or
    - 3. the agent or guardian is not reasonably available.
  - (c) In the case of a patient who lacks capacity, the patient's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the patient is receiving health care.
  - (d) The patient's surrogate shall be an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, who is reasonably available, and who is willing to serve.
  - (e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:
    - 1. the patient's spouse, unless legally separated;
    - 2. the patient's adult child;
    - 3. the patient's parent;
    - 4. the patient's adult sibling;

(Rule 1200-8-2-.12, continued)

5. any other adult relative of the patient; or
  6. any other adult who satisfies the requirements of 1200-8-2-.12(16)(d).
- (f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the patient shall be eligible to serve as the patient's surrogate.
- (g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:
1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the patient or in accordance with the patient's best interests;
  2. The proposed surrogate's regular contact with the patient prior to and during the incapacitating illness;
  3. The proposed surrogate's demonstrated care and concern;
  4. The proposed surrogate's availability to visit the patient during his or her illness; and
  5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.
- (h) If the child lacks capacity and none of the individuals eligible to act as a surrogate under 1200-8-2-.12(16)(c) thru 1200-8-2-.12(16)(g) is reasonably available, the designated physician may make health care decisions for the child after the designated physician either:
1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or
  2. Obtains concurrence from a second physician who is not directly involved in the child's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.
- (i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.
- (j) A surrogate shall make a health care decision in accordance with the patient's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.
- (k) A surrogate who has not been designated by the patient may make all health care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the designated physician and a second independent physician certify in the patient's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions.
- (l) Except as provided in 1200-8-2-.12(16)(m):

(Rule 1200-8-2-.12, continued)

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; and
  2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the patient's treating health care provider.
- (m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:
1. the employee so designated is a relative of the patient by blood, marriage, or adoption; and
  2. the other requirements of this section are satisfied.
- (n) A health care provider may require an individual claiming the right to act as surrogate for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.
- (17) Guardian.
- (a) A guardian shall comply with the patient's individual instructions and may not revoke the patient's advance directive absent a court order to the contrary.
  - (b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.
  - (c) A health care provider may require an individual claiming the right to act as guardian for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.
- (18) A designated physician who makes or is informed of a determination that a patient lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the patient's current clinical record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.
- (19) Except as provided in 1200-8-2-.12(20) thru 1200-8-2-.12(22), a health care provider or institution providing care to a patient shall:
- (a) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and
  - (b) comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.
- (20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.
- (21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:
- (a) contrary to a policy of the institution which is based on reasons of conscience, and

(Rule 1200-8-2-.12, continued)

- (b) the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.
- (22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
- (23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 1200-8-2-.12(20) thru 1200-8-2-.12(22) shall:
  - (a) promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;
  - (b) provide continuing care to the patient until a transfer can be effected or until the determination has been made that transfer cannot be effected;
  - (c) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision; and
  - (d) if a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.
- (24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.
- (25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:
  - (a) complying with a health care decision of a person apparently having authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;
  - (b) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or
  - (c) complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.
- (26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.
- (27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for such identification made in good faith.
- (28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.
- (29) The withholding or withdrawal of medical care from a patient in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(Rule 1200-8-2-.12, continued)

(30) Universal Do Not Resuscitate Order (DNR).

- (a) The Physicians Order for Scope of Treatment (POST) form, a mandatory form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, shall be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be used by a physician for his/her patient with whom he/she has a physician/patient relationship, but only:
  - 1. with the consent of the patient; or
  - 2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or
  - 3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.
- (b) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke a universal do not resuscitate order.
- (c) Universal do not resuscitate orders shall remain valid and in effect until revoked. Qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board for licensing health care facilities or by the department of mental health and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders.
- (d) Nothing in these rules shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.
- (e) If a person with a universal do not resuscitate order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal do not resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the patient's record.
- (f) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices.
- (g) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided.

(Rule 1200-8-2-.13, continued)

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, 68-11-1801 through 68-11-1815. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002. Repeal and new rule filed May 16, 2006; effective July 30, 2006. Amendment filed February 7, 2007; effective April 23, 2007.

**1200-8-2-.13 DISASTER PREPAREDNESS.**

- (1) The administrator of every PCCC shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans, for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff's signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans shall be readily available at all times in the telephone operator's position or at the security center. Each of the following plans shall be exercised annually prior to the month listed in each plan:
  - (a) Fire Safety Procedures Plan (to be exercised at any time during the year) shall include:
    1. Minor fires;
    2. Major fires;
    3. Fighting the fire;
    4. Evacuation procedures; and,
    5. Staff functions by department and job assignment.
  - (b) Tornado/Severe Weather Procedures Plan shall include:
    1. Staff duties by department and job assignment; and,
    2. Evacuation procedures.
  - (c) Bomb Threat Procedures Plan (to be exercised at anytime during the year) shall include:
    1. Staff duties;
    2. Search team, searching the premises;
    3. Notification of authorities;
    4. Location of suspicious objects; and,
    5. Evacuation procedures.
  - (d) Floods Procedures Plans, if applicable, shall include:
    1. Staff duties;
    2. Evacuation procedures; and
    3. Safety procedures following the flood.
  - (e) Severe Cold Weather and Severe Hot Weather Procedures Plans shall include:

(Rule 1200-8-2-.13, continued)

1. Staff duties;
2. Equipment failures;
3. Insufficient HVAC on emergency power;
4. Evacuation procedures; and
5. Emergency food service.

(f) Earthquake Disaster Procedures Plan shall include:

1. Staff duties;
2. Evacuation procedures;
3. Safety procedures; and,
4. Emergency services;

- (2) All facilities shall participate in the Tennessee Emergency Management local/county emergency plan on an annual basis. Participation includes but is not limited to filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation shall be maintained and shall be made available to survey staff as proof of participation.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed June 13, 2002; effective August 27, 2002.

## Appendix A

Vehicle Safety Check  
Preventive Maintenance Check List

Vehicle No. \_\_\_\_\_ Facility \_\_\_\_\_

Use one column per day; write date in shaded area. Check each item (T) if OK, (0) if item needs attention, and (x) if deficiency is corrected. Note any defects and/or corrections at the bottom of sheet. In addition, defects are to be reported to your supervisor.

Exterior ↓	Date → Checked										
Tires											
Turn Signals											
Body (cleanliness)											
Head Lights											
Mirrors											
Wipers											
Body (dents)											

Interior ↓



(Rule 1200-8-2-Appendix A continued)

Brakes									
Steering									
Safety Equipment									
Dash Gauges									
Seat Belts									
Cleanliness									
Body (dents)									

Under Hood ↓

Oil									
Coolant									
Transmission Fluid									
W/W Fluid									
Belts/Hoses									
Brake Fluid									
Amount of Gas Added									
Mileage									
Driver initials									

Defects/Maintenance performed: .....

Remarks: .....

## Appendix B

## Playground Surfacing

## (1) Playground Surface Materials

- (a) A variety of surfaces on the playground provides flexibility and visual interest as well as enjoyment and learning experiences for children. Various play activities require or are facilitated by different surfaces. For example, concrete, asphalt, or hard-packed dirt are better than grass or sand for trike riding and hopscotch; while sand, pebbles, dirt or other “fluid” material are necessary for manipulative activities such as digging or pouring.
- (b) Climbers, swings and other equipment which can take a child’s feet off the ground are in a “fall zone.” A fall of even six (6)” can cause injury to a small child. The fall-zone area under and around equipment where children might fall and be injured shall be covered with impact-absorbing materials which will effectively cushion the fall of a child. According to the Consumer Product Safety Commission (which is mentioned in these standards for additional guidance), falls from equipment onto a hard surface account for 60% to 70% of playground related injuries, and injuries from falls are responsible for over half of all deaths of children after infancy.
- (c) Tricycles and other children’s vehicles are not included in this fall-zone rule, although consideration should be given to placing tricycle tracks within a resilient area and/or providing helmets.

(Rule 1200-8-2-Appendix B, continued)

- (d) Before the variety of materials is examined, another hazard should be considered. In landscaping a play area for children, make certain no poisonous plants, bushes, or grasses are used. The Department has a list of plants to avoid, or consult with your local Poison Control Center if in doubt. (A nursery may not be reliable since nurseries are not accustomed to that question.)
  - (e) Whether loose-fill material or a “unitary” covering is chosen as a resilient surface, it should extend far enough to cover the fall zone, or at least 4 feet and preferably six (6) feet from all sides or perimeters of equipment where children could fall or be propelled (e.g., from arc of swing or exit end of slide).
  - (f) Some surface materials are listed below, with advantages and disadvantages of each given, along with acceptable depth requirements. The range of depths is based on height of equipment in fall zone: the taller the equipment, the more resiliency needed. (Sources for this information are the Consumer Product Safety Commission’s 1992 “Handbook for Public Playground Safety” and “Caring for Our Children”, American Public Health Association/American Academy of Pediatrics [1992]). Administrators are advised to follow guidelines in one of these publications for construction, renovation and maintenance of playgrounds and playground equipment.) Other materials are not precluded; if another material is chosen, use the suggested depth for a similar material (e.g., if cocoa mulch is chosen, use the greatest depth given for wood mulch).
- (2) Natural/Loose-Fill Materials
- Note: Most are not easily accessible to wheel chairs.
- (a) Grass: Provides color and soft appearance to play area, esthetically pleasing. High maintenance. Wears off in high-traffic areas, leaving mud or hard-packed dirt; therefore, unacceptable as a resilient surface under climbers and swings.
  - (b) Coarse sand: Dries fairly quickly (if good drainage system), good for manipulative activities (pouring, sifting, moving), is easily raked. (Sand play area must be apart from sand area around equipment. Sand play area must be covered when not in use and cleaned occasionally.) Depth: 6” min./Eqt. ht: 5 ft.; 12” min./Eqt. ht.: 6 ft. Moderate to high maintenance required because of need to rake when displaced and to clean occasionally. Can cause small cuts and possible eye injury if thrown. CPSC Handbook makes distinction among fine, medium, and coarse.
  - (c) Pea gravel: Drains well, can be played on immediately after rain, suitable for manipulative activities (in protected area away from equipment). Medium size is best (small size can be lodged in ears and noses, large size could cause injury if thrown and is difficult to walk on.) Scatters easily, not recommended for slopes. Depth: 6” to 12” depending on height of equipment. Low maintenance. Must be raked when displaced. Use caution when selecting; must be smooth “river rock.”
  - (d) Rubber mulch: A newer product (untested as of this printing). Provides acceptable resiliency at 6” depth, drains well. Some types leave black marks or dust on skin and clothing. Some objection to heat generated by the sun and its combustibility. Low maintenance. Must be raked when displaced.
  - (e) Sawdust: Inexpensive and drains well when new. High maintenance, requiring a large amount for acceptable resiliency because it scatters easily and must be raked often; must be replaced often because of deterioration. Untested.

(Rule 1200-8-2-Appendix B, continued)

- (f) Wood chips: Drain fairly well. Better drainage provided if placed over sand/dirt combination (perhaps with gravel/dirt layered system). Easily scattered, requiring occasional raking. Depth: 6" to 12" depending on height of equipment. Check for splintering. Rots, needing replacement. Moderate maintenance.
  - (g) Wood mulch: See wood chips for drainage information. Packs down, requiring raking. Less abrasive than sand. Depth: 6" to 12", depending on height of equipment. Rots, needing replacement on at least annual basis. Moderate to high maintenance.
- (3) Unitary Products

These are of solid construction, usually rubber or rubber composition over foam mats or tiles, or they may be "poured." The CPSC "Handbook for Public Playground Safety" (1992 ed.) reads:

"Unitary materials are available from a number of different manufacturers many of whom have a range of materials with differing shock absorbing properties. Persons wishing to install a unitary material as a playground surface should request test data from the manufacturer that should identify the Critical Height of the desired material. In addition, site requirements should be obtained from the manufacturer because some unitary materials require installation over a hard surface while for others this is not required."

Their advantages are their low or no maintenance feature, consistent shock absorbency, wheelchair accessibility, and good footing. The primary disadvantage is the initial high cost; however, most are guaranteed for 5 years but may last longer. Some need to be installed by a professional--some on concrete, some on a level dirt/sand surface. (For more information, see CPSC Handbook.)

Artificial turf should not be used on playgrounds because of its lack of conformity to CPSC standards and because it causes carpet-type burns on falls.

## Appendix C

### Immunization and TB Requirements

In addition to the rules in Section 1200-8-2-.10, these rules are also required of prescribed child care centers.

#### (1) Immunization Rules

- (a) Age-appropriate immunization against the following diseases is required for every child nine (9) weeks of age and above: diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, haemophilus influenza type B, and hepatitis B (and such vaccines and medications as deemed appropriate by the Department of Health in the event of a disease outbreak).
- (b) Records of children shall state whether immunizations required for care are complete, and if not complete, when future immunizations will be given. If immunizations are not continued on time by the parent, the child shall not remain in care. If a child has any known allergies, they shall be indicated in the child's health record. Foreign-born children shall also present evidence of tuberculosis screening.

#### (2) Requirements For Tuberculosis Screening Of Child Care Populations

PCCCs that provide care for periods of less than twenty-four (24) hours per day shall comply with the following health regulations relating to tuberculosis control:

- (a) Staff

(Rule 1200-8-2-Appendix C, continued)

1. It is preferable that staff be screened for tuberculosis within 90 days prior to employment. However, if the situation dictates immediate hire, the staff person shall be screened for signs and symptoms of TB and obtain a mantoux tuberculin skin test no later than two (2) weeks after employment.
2. In immediate hire situations, a TB Screening Inventory shall be completed on the staff person (see attached form entitled "Child Care Staff: Tuberculosis Screening Inventory). If the results of the screening inventory are negative, the staff person may begin work while awaiting the outcome of the mantoux tuberculin skin test. If the results of the screening inventory indicate the likelihood of a positive TB infection, the applicant shall be evaluated by a physician prior to beginning employment. This evaluation may include a chest x-ray and if necessary, other specific tests. If the results of the mantoux tuberculin skin test are positive, the employee shall be evaluated by a physician prior to continuing employment. Persons requiring an evaluation by a physician shall provide documentation indicating that they are free of infectious tuberculosis.
3. Prospective or current staff who are known to have positive tuberculosis reaction shall receive a chest x-ray to rule out infectious tuberculosis. No x-ray is required for persons with documentation of completed preventive therapy. Screening for signs and symptoms of TB shall occur periodically.

## (b) Children

1. Foreign-born

All foreign-born children shall present evidence of tuberculin skin test performed in the United States at any time after twelve (12) months of age. Any child with a positive tuberculin skin test shall be referred to a physician for evaluation. After the initial evaluation, future periodic screening is not required unless the child develops persistent pulmonary symptoms or there is contact with tuberculosis.

2. Native-born

Special screening of children born in the United States is not required unless there is a history of contact to tuberculosis or there are symptoms and/or physical findings suggestive of tuberculosis. If symptoms are present, the child shall be evaluated by a physician. Such children shall provide documentation indicating that they are free of infectious tuberculosis.

Child Care Staff  
Tuberculosis Screening Inventory

Note: This inventory is not a self-evaluation. This form is to be completed by PCCC administrative personnel.

Name: \_\_\_\_\_ Status: (circle one:)      Applicant      Employee

Any child care applicant/employee with the following symptoms should be evaluated promptly for TB:

\_\_\_\_\_ persistent cough (i.e., a cough lasting three weeks or more), especially in the presence of other signs or symptoms compatible with active TB such as:

\_\_\_\_\_ weight loss  
 \_\_\_\_\_ night sweats  
 \_\_\_\_\_ bloody sputum

(Rule 1200-8-2-Appendix I, continued)

\_\_\_\_\_anorexia  
 \_\_\_\_\_fever

If the above symptoms are indicated, the individual should not begin or continue employment until a diagnosis of TB has been excluded or until the person is on therapy and a determination has been made that the individual is noninfectious.

## Inventory Results:

\_\_\_\_\_ indicated - medical confirmation of noninfectious status required

\_\_\_\_\_ not indicated - no further action necessary

Signature: \_\_\_\_\_

Date Completed: \_\_\_\_\_

## Medical Confirmation:

\_\_\_\_\_ confirmation of noninfectious status received

Signature: \_\_\_\_\_

Date Received: \_\_\_\_\_

**APPENDIX I**

## (1) Physician Orders for Scope of Treatment (POST) Form

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED	
<b>Physician Orders for Scope of Treatment (POST)</b>  This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, <u>first</u> follow these orders, <u>then</u> contact physician.	Patient's Last Name
	First Name/Middle Initial
	Date of Birth
<b>Section A</b>  Check One Box Only	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> Patient has no pulse <u>and/or</u> is not breathing. <input type="checkbox"/> <u>Resuscitate</u> (CPR) <input type="checkbox"/> <u>Do Not Attempt Resuscitate</u> (DNR/no CPR)  When not in cardiopulmonary arrest, follow orders in B, C, and D.
<b>Section B</b>  Check One Box Only	<b>MEDICAL INTERVENTIONS.</b> Patient has pulse <u>and/or</u> is breathing.  <input type="checkbox"/> <b>Comfort Measures</b> Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer <u>only</u> if comfort needs cannot be met in current location.  <input type="checkbox"/> <b>Limited Additional Interventions</b> Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.

(Rule 1200-8-2-Appendix I, continued)

	<input type="checkbox"/> Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care.  Other Instructions: _____		
Section C  Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions:  <input type="checkbox"/> No Antibiotics <input type="checkbox"/> Antibiotics  Other Instructions: _____		
Section D  Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No IV fluids (provide other measures to assure comfort)  <input type="checkbox"/> IV fluids for a defined trial period  <input type="checkbox"/> IV fluids long-term if indicated         </div> <div> <input type="checkbox"/> No feeding tube  <input type="checkbox"/> Feeding tube for a defined trial period  <input type="checkbox"/> Feeding tube long-term         </div> </div> Other Instructions: _____		
Section E  Must be Completed	Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Health care agent <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Parent of minor Other: _____ (Specify)		The Basis for These Orders Is: (Must be completed) <input type="checkbox"/> Patient's preferences <input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown) <input type="checkbox"/> Medical indications <input type="checkbox"/> (Other) _____
	Physician Name (Print)	Physician Phone Number	Office Use Only
	Physician Signature (Mandatory)	Date	
COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED			

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY			
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative			
Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.			
(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)			
Signature	Name (print)	Relationship (write "self" if patient)	
Contact Information			
Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared
Directions for Health Care Professionals			
<u>Completing POST</u>  Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.  POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.  Photocopies/faxes of signed POST forms are legal and valid.			
<u>Using POST</u>			

(Rule 1200-8-2-Appendix I, continued)

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

#### Reviewing POST

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

**COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED**

## (2) Advance Care Plan Form

### ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_

#### Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

(Rule 1200-8-2-Appendix I, continued)

- ☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>CPR (Cardiopulmonary Resuscitation):</u> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Life Support/Other Artificial Support:</u> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Treatment of New Conditions:</u> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Tube feeding/IV fluids:</u> Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.: \_\_\_\_\_

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

- ☐ Any organ/tissue    ☐ My entire body    ☐ Only the following organs/tissues: \_\_\_\_\_

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. \_\_\_\_\_  
I witnessed the patient's signature on this form. Signature of witness number 1



(Rule 1200-8-2-Appendix I, continued)

2. I am a competent adult who is not named as the agent.

I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

This document may be notarized instead of witnessed:  
-----

STATE OF TENNESSEE

COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE**

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

Acknowledgement to Project GRACE for inspiring the development of this form.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

**Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007.